The Secretary for Health Services
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April 3, 2003

Audiologist Provider Letter #A-1
Optician Letter #A-2
Optometrist Letter #A-135
Physician Letter #A-337
Physician Group Letter #A-4
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Podiatrist Letter #A-173
Primary Care Letter #A-343

Dear Provider:

On May 1, 2003, the Department for Medicaid Services, following the lead of other states in the Southeast Region, will require certain categories of Medicaid recipients to make a $2 per visit co-payment for designated services in accordance with 901 KAR 1:604. A visit is defined as all services provided by given provider on a given date of service. Recipients who must make co-payments will have the phrase "*Subject to Co-payment" printed on their Medicaid cards and have an asterisk beside their names.

Providers must collect the required co-payment from the recipients. Medicaid will reduce its amount of payment by $2 per visit per day for applicable services. This action will not require a change in the way that Medicaid is billed for these services.

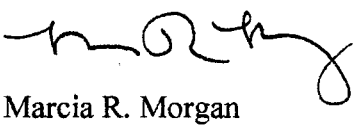
Providers should try to collect the co-payment at the time of service. However, under state and federal law, recipients cannot be denied care by a provider because of their inability to make a Medicaid-required co-payment at the time for service. Nevertheless, the recipient still owes the co-payment. If it is the routine business practice of a provider to terminate future services to an individual with uncollected debt the provider may, with advanced notice, include uncollected co-payments under this practice.

The following providers that bill for services covered under Medicaid will be impacted by this change: Audiologists (70), Chiropractors (85), Dentists (60), Dental Groups (61), Hearing Aid Providers (50), Opticians (52), Optometrists (77), and Podiatrists (80).

Physicians (64), Physician Groups (65), ARNPs (78), Rural Health (35), and Primary Care (31) providers must charge a $2 co-payment only for general ophthalmologic services (92002, 92004, 92012, 92014) only.

The enclosed question and answer document will provide more detailed explanation and clarification of the new co-payment methodology. If additional information is needed, please contact Duane Dringenburg, of the Physicians and Specialty Services Division at 502-564-5969.

Sincerely,



Marcia R. Morgan
Secretary

MRM/DCD/tp

Enclosure

Most Frequently Asked Questions Regarding Changes to Medicare Crossover Payment Methodology

1) Why is the Department making this change?

The Department for Medicaid Services (DMS) is faced with a large budget deficit. The projected annual savings from this change is significant and will help address Medicaid budget constraints by requiring Medicaid recipients to assume responsibility for some of the cost of their health care. Co-payments for pharmacy services have been required since August 1, 2002. The Department now is extending the co-payment requirement to additional services.

2) How is this different from the way you are currently paying providers?

Currently, DMS makes the full allowable payment for covered services except pharmacy. On May 1, 2003, certain additional providers must collect a $2 per visit co-payment from the recipient at the time of service. Medicaid will reduce its provider payments by the amount of the required recipient co-payments.

If recipients are unable to make the co-payment when they receive a service, they still owe the co-payment and should pay it as soon as possible. Under federal and state law providers cannot refuse to provide a service solely because an individual cannot pay the require co-payment at the time of service. However, if there is a history of non-payment, the provider may with prior notice stop serving the individual. Medicaid providers can always exercise freedom of choice as to which recipients they serve.

3) How will the recipient be notified?

Currently enrolled recipients will receive a special co-payment notice mailed to them with their medical cards. Local eligibility determination offices will inform new Medicaid applicants of their co-payment responsibilities.

4) How will a health care service provider know who must pay the co-payments?

Recipients for whom a co-payment is required will be identified by the phrase "*Subject to Co-payment" on their Medicaid cards. The following categories of recipients are not subject to co-payments:

- Pregnant women up to sixty days post partum
- Children under the age of 18
- Residents of nursing facilities, personal care homes, family care homes or intermediate care facilities for individuals with mental retardation or developmental disabilities (ICF/MR)
- Recipients receiving hospice services
- Foster Children in state custody
- American Indians and Alaskan natives served through KCHIP

5) When is this change effective?

The change is effective for services provided on or after May 1, 2003 by the provider groups listed below.

6) What providers will be impacted by this change?

The following providers that bill for services covered under Medicaid must beginning May 1, 2003 charge the $2 per visit per day co-payment: Audiologists (70), Chiropractors (85), Dentists (60), Dental Groups (61), Hearing Aid Dealers (50), Opticians (52), Optometrists (77), and Podiatrists (80). Physicians (64), Physician Groups (65), Advanced Registered Nurse Practitioners (78), Rural Health Clinics (35), and Primary Care Centers (31) must charge a co-payment for only general ophthalmologic services: 92002, 92004, 92012, and 92014.

7) Are Passport enrollees subject to these co-payments?

Many Passport enrollees fall into Medicaid categories that are subject to co-payment. Passport will administer the co-payment system for its enrolled members for services covered under its contract with the state. Passport will distribute applicable informational material to its network of providers.